



General Assembly

February Session, 2016

***Raised Bill No. 34***

LCO No. 462



Referred to Committee on INSURANCE AND REAL ESTATE

Introduced by:  
(INS)

***AN ACT CONCERNING DISPENSATION AND COVERAGE OF A  
PRESCRIBED DRUG FOR A CHRONIC DISEASE DURING CERTAIN  
ADVERSE DETERMINATION REVIEWS, AND DECREASING THE TIME  
FRAMES FOR URGENT CARE ADVERSE DETERMINATION REVIEW  
REQUESTS.***

Be it enacted by the Senate and House of Representatives in General  
Assembly convened:

1 Section 1. Subsection (b) of section 38a-591d of the 2016 supplement  
2 to the general statutes is repealed and the following is substituted in  
3 lieu thereof (*Effective January 1, 2017*):

4 (b) With respect to a nonurgent care request:

5 (1) (A) For a prospective or concurrent review request, a health  
6 carrier shall make a determination within a reasonable period of time  
7 appropriate to the covered person's medical condition, but not later  
8 than fifteen calendar days after the date the health carrier receives such  
9 request, and shall notify the covered person and, if applicable, the  
10 covered person's authorized representative of such determination,  
11 whether or not the carrier certifies the provision of the benefit.

12 (B) If the review under subparagraph (A) of this subdivision is a  
13 review of a grievance involving a concurrent review request, pursuant  
14 to 45 CFR 147.136, as amended from time to time, the treatment shall  
15 be continued without liability to the covered person until the covered  
16 person has been notified of the review decision.

17 (C) (i) If the review under subparagraph (A) of this subdivision is a  
18 review of a grievance involving a prospective review request relating  
19 to the dispensing of a drug for a chronic disease, other than a schedule  
20 II or III controlled substance, that is prescribed by a licensed  
21 participating provider who is a specialist in such chronic disease, the  
22 health carrier shall issue an electronic authorization to the covered  
23 person's pharmacy for the dispensing of a temporary supply of such  
24 drug sufficient for the duration of such review until the covered  
25 person has been notified of the review decision. Such authorization  
26 shall include confirmation of the availability of payment for such  
27 supply of such drug.

28 (ii) Not later than twenty-four hours after the health carrier has  
29 issued such authorization to the pharmacy and prior to the pharmacy's  
30 dispensation of such drug, such health carrier shall confirm with such  
31 participating provider the provider's concurrence with the dispensing  
32 of such temporary supply of such drug. If such participating provider  
33 does not concur, the health carrier shall cancel such authorization.

34 (iii) The provisions of this subparagraph shall not apply to a  
35 grievance or review of an adverse determination under this section  
36 concerning the substitution of a generic drug or another brand name  
37 drug for a prescribed brand name drug unless the prescribing licensed  
38 participating provider has specified that there shall be no substitution  
39 for the specified brand name drug.

40 (2) For a retrospective review request, a health carrier shall make a  
41 determination within a reasonable period of time, but not later than  
42 thirty calendar days after the date the health carrier receives such

43 request.

44 (3) The time periods specified in subdivisions (1) and (2) of this  
45 subsection may be extended once by the health carrier for up to fifteen  
46 calendar days, provided the health carrier:

47 (A) Determines that an extension is necessary due to circumstances  
48 beyond the health carrier's control; and

49 (B) Notifies the covered person and, if applicable, the covered  
50 person's authorized representative prior to the expiration of the initial  
51 time period, of the circumstances requiring the extension of time and  
52 the date by which the health carrier expects to make a determination.

53 (4) (A) If the extension pursuant to subdivision (3) of this subsection  
54 is necessary due to the failure of the covered person or the covered  
55 person's authorized representative to provide information necessary to  
56 make a determination on the request, the health carrier shall:

57 Sec. 2. Subsection (c) of section 38a-591e of the general statutes is  
58 repealed and the following is substituted in lieu thereof (*Effective*  
59 *January 1, 2017*):

60 (c) (1) (A) When conducting a review of an adverse determination  
61 under this section, the health carrier shall ensure that such review is  
62 conducted in a manner to ensure the independence and impartiality of  
63 the clinical peer or peers involved in making the review decision.

64 (B) If the adverse determination involves utilization review, the  
65 health carrier shall designate an appropriate clinical peer or peers to  
66 review such adverse determination. Such clinical peer or peers shall  
67 not have been involved in the initial adverse determination.

68 (C) The clinical peer or peers conducting a review under this section  
69 shall take into consideration all comments, documents, records and  
70 other information relevant to the covered person's benefit request that  
71 is the subject of the adverse determination under review, that are

72 submitted by the covered person or the covered person's authorized  
73 representative, regardless of whether such information was submitted  
74 or considered in making the initial adverse determination.

75 (D) Prior to issuing a decision, the health carrier shall provide free  
76 of charge, by facsimile, electronic means or any other expeditious  
77 method available, to the covered person or the covered person's  
78 authorized representative, as applicable, any new or additional  
79 documents, communications, information and evidence relied upon  
80 and any new or additional scientific or clinical rationale used by the  
81 health carrier in connection with the grievance. Such documents,  
82 communications, information, evidence and rationale shall be  
83 provided sufficiently in advance of the date the health carrier is  
84 required to issue a decision to permit the covered person or the  
85 covered person's authorized representative, as applicable, a reasonable  
86 opportunity to respond prior to such date.

87 (2) If the review under subdivision (1) of this subsection is an  
88 expedited review, all necessary information, including the health  
89 carrier's decision, shall be transmitted between the health carrier and  
90 the covered person or the covered person's authorized representative,  
91 as applicable, by telephone, facsimile, electronic means or any other  
92 expeditious method available.

93 (3) If the review under subdivision (1) of this subsection is an  
94 expedited review of a grievance involving an adverse determination of  
95 a concurrent review request, pursuant to 45 CFR 147.136, as amended  
96 from time to time, the treatment shall be continued without liability to  
97 the covered person until the covered person has been notified of the  
98 review decision.

99 (4) (A) If the review under subdivision (1) of this subsection is a  
100 review of a grievance involving a prospective review request relating  
101 to the dispensing of a drug for a chronic disease, other than a schedule  
102 II or III controlled substance, that is prescribed by a licensed

103 participating provider who is a specialist in such chronic disease, the  
104 health carrier shall issue an electronic authorization to the covered  
105 person's pharmacy for the dispensing of a temporary supply of such  
106 drug sufficient for the duration of such review until the covered  
107 person has been notified of the review decision. Such authorization  
108 shall include confirmation of the availability of payment for such  
109 supply of such drug.

110 (B) Not later than twenty-four hours after the health carrier has  
111 issued such authorization to the pharmacy and prior to the pharmacy's  
112 dispensation of such drug, such health carrier shall confirm with such  
113 participating provider the provider's concurrence with the dispensing  
114 of such temporary supply of such drug. If such participating provider  
115 does not concur, the health carrier shall cancel such authorization.

116 (C) The provisions of this subdivision shall not apply to a grievance  
117 or review of an adverse determination under this section concerning  
118 the substitution of a generic drug or another brand name drug for a  
119 prescribed brand name drug unless the prescribing licensed  
120 participating provider has specified that there shall be no substitution  
121 for the specified brand name drug.

122 Sec. 3. Subdivision (1) of subsection (c) of section 38a-591d of the  
123 2016 supplement to the general statutes is repealed and the following  
124 is substituted in lieu thereof (*Effective January 1, 2017*):

125 (1) (A) Unless the covered person or the covered person's  
126 authorized representative has failed to provide information necessary  
127 for the health carrier to make a determination and except as specified  
128 under subparagraph (B) of this subdivision, the health carrier shall  
129 make a determination as soon as possible, taking into account the  
130 covered person's medical condition, but not later than [seventy-two]  
131 forty-eight hours after the health carrier receives such request,  
132 provided, if the urgent care request is a concurrent review request to  
133 extend a course of treatment beyond the initial period of time or the

134 number of treatments, such request is made at least twenty-four hours  
135 prior to the expiration of the prescribed period of time or number of  
136 treatments.

137 (B) Unless the covered person or the covered person's authorized  
138 representative has failed to provide information necessary for the  
139 health carrier to make a determination, for an urgent care request  
140 specified under subparagraph (B) or (C) of subdivision (38) of section  
141 38a-591a, the health carrier shall make a determination as soon as  
142 possible, taking into account the covered person's medical condition,  
143 but not later than twenty-four hours after the health carrier receives  
144 such request, provided, if the urgent care request is a concurrent  
145 review request to extend a course of treatment beyond the initial  
146 period of time or the number of treatments, such request is made at  
147 least twenty-four hours prior to the expiration of the prescribed period  
148 of time or number of treatments.

149 Sec. 4. Subdivision (1) of subsection (d) of section 38a-591e of the  
150 general statutes is repealed and the following is substituted in lieu  
151 thereof (*Effective January 1, 2017*):

152 (d) (1) The health carrier shall notify the covered person and, if  
153 applicable, the covered person's authorized representative, in writing  
154 or by electronic means, of its decision within a reasonable period of  
155 time appropriate to the covered person's medical condition, but not  
156 later than:

157 (A) For prospective review and concurrent review requests, thirty  
158 calendar days after the health carrier receives the grievance;

159 (B) For retrospective review requests, sixty calendar days after the  
160 health carrier receives the grievance;

161 (C) For expedited review requests, except as specified under  
162 subparagraph (D) of this subdivision, [seventy-two] forty-eight hours  
163 after the health carrier receives the grievance; and

164 (D) For expedited review requests of a health care service or course  
165 of treatment specified under subparagraph (B) or (C) of subdivision  
166 (38) of section 38a-591a, twenty-four hours after the health carrier  
167 receives the grievance.

168 Sec. 5. Subdivision (1) of subsection (i) of section 38a-591g of the  
169 general statutes is repealed and the following is substituted in lieu  
170 thereof (*Effective January 1, 2017*):

171 (i) (1) The independent review organization shall notify the  
172 commissioner, the health carrier, the covered person and, if applicable,  
173 the covered person's authorized representative in writing of its  
174 decision to uphold, reverse or revise the adverse determination or the  
175 final adverse determination, not later than:

176 (A) For external reviews, forty-five calendar days after such  
177 organization receives the assignment from the commissioner to  
178 conduct such review;

179 (B) For external reviews involving a determination that the  
180 recommended or requested health care service or treatment is  
181 experimental or investigational, twenty calendar days after such  
182 organization receives the assignment from the commissioner to  
183 conduct such review;

184 (C) For expedited external reviews, except as specified under  
185 subparagraph (D) of this subdivision, as expeditiously as the covered  
186 person's medical condition requires, but not later than [seventy-two]  
187 forty-eight hours after such organization receives the assignment from  
188 the commissioner to conduct such review;

189 (D) For expedited external reviews involving a health care service or  
190 course of treatment specified under subparagraph (B) or (C) of  
191 subdivision (38) of section 38a-591a, as expeditiously as the covered  
192 person's medical condition requires, but not later than twenty-four  
193 hours after such organization receives the assignment from the

194 commissioner to conduct such review; and

195 (E) For expedited external reviews involving a determination that  
 196 the recommended or requested health care service or treatment is  
 197 experimental or investigational, as expeditiously as the covered  
 198 person's medical condition requires, but not later than five calendar  
 199 days after such organization receives the assignment from the  
 200 commissioner to conduct such review.

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>January 1, 2017</i>	38a-591d(b)
Sec. 2	<i>January 1, 2017</i>	38a-591e(c)
Sec. 3	<i>January 1, 2017</i>	38a-591d(c)(1)
Sec. 4	<i>January 1, 2017</i>	38a-591e(d)(1)
Sec. 5	<i>January 1, 2017</i>	38a-591g(i)(1)

***Statement of Purpose:***

To establish procedures for the dispensation of and coverage for a prescribed drug for a chronic disease during certain adverse determination reviews, and decrease the time frame for urgent care adverse determination review requests from seventy-two hours to forty-eight hours.

*[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]*